

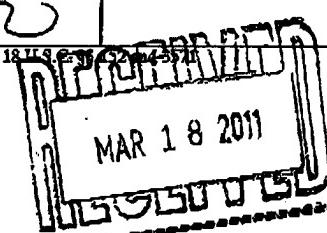
Case 10-32160-5-mcr Claim 5 Filed 03/23/11 Desc Main Document Page 1 of 8

UNPAID

B10 (Official Form 10) (04/10)

UNITED STATES BANKRUPTCY COURT Northern District of New York		PROOF OF CLAIM	
Name of Debtor: Jonathan E. Fuller Carrie L. Fuller	Case Number: 10-32160-5-mcr		
NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503.			
Name of Creditor (the person or other entity to whom the debtor owes money or property):  Neonatal Associates of CNY	<input type="checkbox"/> Check this box to indicate that this claim amends a previously filed claim.		
Name and address where notices should be sent:  Neonatal Associates of CNY 736 Irving Ave Rm 9100 Syracuse, NY 13210-1627	Court Claim Number: _____ (If known)		
<b>FILED</b>		Filed on: MAR 23 2011	
Telephone number:			
Name and address where payment should be sent (if different from above):  OFFICE OF THE BANKRUPTCY CLERK SYRACUSE, NY	<input type="checkbox"/> Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.		
Telephone number: 315-410-7009	<input type="checkbox"/> Check this box if you are the debtor or trustee in this case.		
1. Amount of Claim as of Date Case Filed: \$ 40.00	5. Amount of Claim Entitled to Priority under 11 U.S.C. §507(a). If any portion of your claim falls in one of the following categories, check the box and state the amount.		
If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4.	<input type="checkbox"/> Specify the priority of the claim.		
If all or part of your claim is entitled to priority, complete item 5.	<input type="checkbox"/> Domestic support obligations under 11 U.S.C. §507(a)(1)(A) or (a)(1)(B).		
<input type="checkbox"/> Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.	<input type="checkbox"/> Wages, salaries, or commissions (up to \$11,725*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. §507 (a)(4).		
2. Basis for Claim (Copy on reverse side) (See instruction #2 on reverse side)	<input type="checkbox"/> Contributions to an employee benefit plan - 11 U.S.C. §507 (a)(3).		
3. Last four digits of any number by which creditor identifies debtor: _____	<input type="checkbox"/> Up to \$2,600* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. §507 (a)(7).		
3a. Debtor may have scheduled account as: _____ (See instruction #3a on reverse side)	<input type="checkbox"/> Taxes or penalties owed to governmental units - 11 U.S.C. §507 (a)(8).		
4. Secured Claims (See instruction #4 on reverse side) Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information.	<input type="checkbox"/> Other - Specify applicable paragraph of 11 U.S.C. §507 (a) _____		
Nature of property or right of setoff: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other Describe: _____	Amount entitled to priority: _____		
Value of Property: \$ _____ Annual Interest Rate: %			
Amount of arreage and other charges as of time case filed included in secured claim, if any: \$ _____ Basis for perfection: _____			
Amount of Secured Claims: \$ _____ Amount Unsecured: \$ _____			
6. Creditors: The amount of all payments on this claim has been credited for the purpose of making this proof of claim.			
7. Documentation: Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of a security interest. You may also attach a summary. (See instruction 7 and definition of "redacted" on reverse side.)			
DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.			
If the documents are not available, please explain: _____			
Date: 3/21/11	Signature: The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.		FOR COURT USE ONLY

Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. § 152 and 523.



MAKE CHECKS PAYABLE TO Case 10-32160-5-mcr Claim 5 Filed 03/23/11 Desc Main Document Page 2 of 8

**Neonatal Associates Of CNY**  
 736 Irving Ave  
 Room 9100  
 Syracuse, NY 13210

03/21/11 \$20.00 24820

**STATEMENT**

||||||||||||||||||

**Fuller, Carrie L**  
 100 South Terry Rd  
 Syracuse, NY 13219

**Neonatal Associates Of CNY**  
 736 Irving Ave  
 Room 9100  
 Syracuse, NY 13210

(315) 470-7009

*Twin A*

DATE	DESCRIPTION OF SERVICE	AMOUNT	INSUR BALANCE	PATIENT BALANCE	BALANCE
02/23/10	ENCOUNTER 63841 FOR TYLER WITH BODE MD, MICHELLE M				
02/23/10	99244 - Clinic Office Visit	\$350.00		\$20.00	
03/18/10	BC/BS Payment (3 (Copayment Applied))	-\$189.63			
03/18/10	BC/BS Adjustment (3 (Copayment Applied))	-\$140.37			
08/18/10	Bankruptcy	-\$20.00			
03/21/11	Adjustment Positive	\$20.00			
	ENCOUNTER TOTAL	\$20.00	\$0.00	\$20.00	\$20.00

ACCOUNT NBR	CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS	TOTAL ACCOUNT BALANCE
24820	\$0.00	\$0.00	\$0.00	\$0.00	\$20.00	\$20.00

**MESSAGE:**

CREDIT CARDS ARE NOW BEING ACCEPTED.

PLEASE PAY  
 THIS AMOUNT »»» \$20.00

**\*\* PAYMENT DUE UPON RECEIPT • THANK YOU \*\***  
**STATEMENT**

BUREAUCRATIC AUTONOMY

PROVIDER ID 1228283271 NEONATAL ASSOC OF ONE PC  
758 TRYING AVE RM B105 SYRACUSE NY 13210

**Excelius** • 105 Court Street, Rochester, NY 14647

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## Neonatal Associates of Central New York, PC

### PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, and/or health care operations.

As our patient we want you to know that we respect the privacy of your personal health information (PHI) and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

In the event your account were to go to collections for lack of payment, you will be responsible for any and all collection and/or attorney fees.

Carrie L. Fuller  
Signature

6-9-09  
Date

Carrie L. Fuller  
Print Name

MAKES CHECKS PAYABLE TO 10-32160-5-mcr Claim 5 Filed 03/23/11 Desc Main Document Page 5 of 8

**Neonatal Associates Of CNY**  
736 Irving Ave  
Room 9100  
Syracuse, NY 13210

03/21/11 \$20.00 24820

**STATEMENT**

111111111111111111111111

**Fuller, Carrie L**  
100 South Terry Rd  
Syracuse, NY 13219

**Neonatal Associates Of CNY**  
736 Irving Ave  
Room 9100  
Syracuse, NY 13210

(315) 470-7009

TWTR 8

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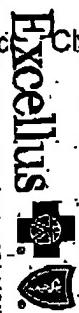
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**\*\* PAYMENT DUE UPON RECEIPT \* THANK YOU \*\*  
STATEMENT**

**PAGE: 1**



PHYSICIAN REMITTANCE SUMMARY

PROVIDER ID 122828271  
NEONATAL ASSOC OF NY PO  
736 IRVING AVE RM 9198  
SYRACUSE NY 13210

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**Neonatal Associates of Central New York, PC**

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Carrie Fuller  
Signature

6-9-09  
Date

Carrie L. Fuller  
Print Name